TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic PA

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-17-2219-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After requesting reconsideration in a timely fashion VIA mail to the Hartford it is quite evident that the carrier is unwilling to reimburse our facility for services rendered and that were preauthorized. We submitted our bills and clinical documentation in a timely fashion. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $379.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Physical and Occupation Therapy Specialty Guide – Part B developed by Novitas Solutions (Medicare Administrative Contract (MAC) for TX) recommends the normal PT session time at 45-60 minutes. The 60 minute PT session duration is also recommended in the Physical Therapy section of ODG. Per Medicare Guidelines, Code G0283 requires a "GP", "GO" or "GN" modifier."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28 Through November 30, 2016	Physical Therapy	$379.48	$203.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization and concurrent

utilization review.

3. 28 Texas Administrative Code §133.240 sets out the guidelines for medical payments and denials.
4. 28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.
5. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
6. 28 Texas Administrative Code §19.2003 (b)(31) defines retrospective review.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 163 – the charge for this procedure exceeds the unit value and/or the multiple procedure rules
   - TXM9 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding, billing and reimbursement methodologies
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
   - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance

Issues

1. Is the requestor's position supported?
2. Is the carrier's position supported?
3. Is the denial for Code G0283 supported?
4. What is the rule that applies to reimbursement?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for professional medical services,

   CPT Code 97110, GP, 4 units – "Therapeutic procedure, 1 or more areas, each 15 minutes" date of service November 28, 2016,

   CPT 97140, GP, 2 units – "Manual therapy techniques, 1 or more regions, each 15 minutes" for date of service November 28, 2016,

   CPT G0283, GP, 1 unit – "Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care" for date of service November 28, 2016

   CPT 97110, GP, 4 units – "Therapeutic procedure, 1 or more areas, each 15 minutes" date of service November 30, 2016

   The requestor states in pertinent part …"services rendered and that were preauthorized." Review of the submitted documentation found prior authorization number "2230678" listed in box 23 of medical claim and a document dated November 2, 2016 find the following:

   Requested Services: Active Physical Rehab 3x4 wks right shoulder 97110
   Start Date 10/26/2016 End Date 12/26/2016
   Determination Approval
   Authorization #: 2230678

   28 Texas Administrative Code §134.600 (c) (5) states,

   The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

   (1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

Based on the evidence submitted with this dispute, the Division finds Procedure Code 97110 was prior authorized and no limitations on the number of units was placed on the authorization.

Therefore, the requestor's position is supported for Procedure Code 97110 and the applicable fee guideline will be calculated per Division rules and fee guidelines.

2. The carrier states in pertinent part of their position "…normal PT session time at 45-60 minutes. The 60 minute PT session duration is also recommended in the Physical Therapy section of ODG."

   The insurance carrier denied disputed service 97140 with claim adjustment reason code 119 – "Benefit maximum for this time period or occurrence has been reached" and 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services."

   28 Texas Administrative Code §133.240 (q) states in pertinent part,

   > When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

   28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage. Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

   No documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required. The insurance carrier failed to follow the appropriate administrative process and remedy in order to address its assertions regarding medical necessity. Therefore, the carrier's position and denials are not supported and the services in dispute will be reviewed per applicable fee guidelines.

3. Procedure code G0283, service date November 28, 2016, the carrier denied as 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing and TXM9 – "The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding, billing and reimbursement methodologies."

   > CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 2868, Date: February 6, 2014, Change Request 8556. 20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims, available at www.cms.hhs.gov, states, "*The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services.*"

28 Texas Administrative Code §134.203 (b) states in pertinent part,

> For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
>
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the submitted medical claim finds the required modifier was not included on the claim line for G0283. Therefore, the carrier's denial is supported. No additional payment is recommended.

4. 28 Texas Administrative Code 134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is date of service yearly conversion factor.

The maximum allowable reimbursement is calculated as follows:

1. Procedure code 97110, service date November 28, 2016, has a MAR of $52.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $52.29. The PE reduced rate is $39.72 at 3 units is $119.16. The total is $171.45.

2. Procedure code 97140, service date November 28, 2016 has a MAR of $48.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $36.87 at 2 units is $73.74.

3. Procedure code 97110, service date November 30, 2016 has a MAR of $52.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $52.29. The PE reduced rate is $39.72 at 3 units is $119.16. The total is $171.45.

5. The total allowable reimbursement for the services in dispute is $416.64. This amount less the amount previously paid by the insurance carrier of $213.46 leaves an amount due to the requestor of $203.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $203.18.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $203.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		May 25, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.